P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N NO. 01-18F

FROM Eileen I. Elliott, Commissioner
for the Secretary

DATE September 14, 2001

SUBJECTS Elimination of Dental Services Coverage in the Vermont Health Access Plan (VHAP); and Cost Sharing Changes in the Medicaid, VHAP-Pharmacy, and VScript Programs

CHANGES ADOPTED EFFECTIVE 10/1/01

INSTRUCTIONS

_X_ **Maintain Manual - See instructions below.**

___ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**

___ **Information or Instructions - Retain until _____**

MANUAL REFERENCE(S)

M103 3203 4003
M150 3303

This bulletin changes Medicaid, VHAP, VHAP-Pharmacy, and VScript policy as required by the fiscal year 2002 budget act, Act 63 (2001), as enacted by the Vermont General Assembly.

Changes in Pharmacy Copayments for Medicaid Beneficiaries

The budget act requires beneficiaries who are enrolled in the primary care case management program or a managed health care plan to pay pharmacy copayments in the amount of $1.00 for prescriptions or refills costing $29.99 or less, $2.00 for prescriptions or refills costing $30.00 up to $49.99, and $3.00 for prescriptions or refills costing $ 50.00 or more. This copayment requirement does not apply to beneficiaries who are patients in a participating long-term care facility, under the age of 18, pregnant, or in the 60-day post-pregnancy period. The budget act also requires Medicaid beneficiaries with copayment requirements to pay a pharmacy copayment of $3.00 for prescriptions or refills costing $50.00 or more. These changes are subject to approval by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

Changes in Pharmacy Copayments for VHAP-Pharmacy Beneficiaries

The budget act authorizes a pharmacy copayment of $3.00 for each prescription or refill costing $50.00 or more for VHAP-Pharmacy beneficiaries, subject to approval by CMS.

Changes in the VScript Program

The budget act increases copayments for VScript beneficiaries with household incomes of 175 percent of the federal poverty level or less, subject to CMS approval. Specifically, copayments for prescriptions with a usual and customary charge of $29.99 or less will increase from $1.00 to $2.00 for each prescription or refill; copayments for prescriptions with a usual and customary charge of $30.00 or more will increase from $2.00 to $4.00 for each prescription or refill.

Changes in the VHAP Managed Care Benefit

The budget act eliminates coverage for limited dental services in the VHAP managed care program, subject to approval by the CMS.

At the request of the Legislative Committee on Administrative Rules the department has delayed the elimination of dental services for VHAP managed care beneficiaries until December 1, 2001.

Specific Changes to Policy Pages

M103.2 P.3	Adds pharmacy copayment requirements for Medicaid beneficiaries enrolled in a managed health care plan; implementation is subject to CMS approval.
M103.3 P.7	Adds pharmacy copayment requirements for Medicaid beneficiaries enrolled in the primary care case management (PCCM) program; implementation is subject to CMS approval.
M150	Adds pharmacy copayment of $3.00 for each prescription or prescription refill costing $50.00 or more for all beneficiaries with copayment requirements; implementation is subject to CMS approval.
M150.1	Deletes the language "[s]ervices provided by a Health Maintenance Organization (HMO) or other prepaid health plan to recipients" because subject to CMS approval, these beneficiaries will be required to make copayments. Renumbers the subsequent subsections.
3203	Increases copayments for beneficiaries whose household income exceeds 150 percent and is less than or equal to 175 percent of the federal poverty level to $2.00 for prescriptions costing $29.99 or less and to $4.00 for prescriptions costing $30.00 or more; implementation is subject to CMS approval.
3303.1 P.2	Adds pharmacy copayment of $3.00 per prescription or prescription refill costing $50.00 or more; implementation is subject to CMS approval; deletes obsolete effective date. Changes reference to the Health Care Financing Administration to CMS.

4003.1 Adds language eliminating coverage for limited dental services subject to approval by CMS. Changes reference to the Department of Social Welfare to PATH.

At the request of the Legislative Committee on Administrative Rules the department has delayed the elimination of dental services for VHAP managed care beneficiaries until December 1, 2001.

A public hearing was held on July 23, 2001, at 1:00 p.m., in the Secretary's Conference Room, Waterbury State Office Complex. No members of the public attended the hearing.

Written comments were received on behalf of the Community of Vermont Elders (COVE), the Office of Health Care Ombudsman, Vermont Coalition for Disability Rights (VCDR), and the Vermont Low Income Advocacy Council (VLIAC). The comments relevant to the proposed policy are summarized below. Other comments, on topics not specifically addressed by the proposed policy, are not summarized.

Written Summary of the Comments

Comment: One commenter expressed disappointment that VHAP dental services were cut in the budget.

Response: The department is concerned about the sustainability of the VHAP programs. The department's budget included a number of recommendations for benefit and cost sharing changes. The Legislature chose not to accept many of the benefit changes but did eliminate coverage of dental services under the VHAP program. In addition, the dental community has expressed its perspective that, if choices are to be made, dental care for children is the priority.

Comment: Two commenters assumed that VHAP dental services would not be eliminated as a VHAP benefit until January 1, 2002. One commenter requested the department reconsider the proposed date for the implementation of this change.

Response: The statute states "upon HCFA approval" and, since a rule change is required for this to happen, the department has stated that the rule will become effective on October 1, 2001, or upon the date of CMS approval, whichever is later. For budgeting purposes, the department projected six months of savings, consistent with the projected time for CMS approval. If the rule were to be effective January 1, 2001, savings would not be seen for several more months due to the lag in claims submissions following the provision of services. Given the deterioration of the state's revenue situation, the department needs to be conservative in efforts to generate savings.

Comment: One commenter requested the department's position on coverage of dental emergencies for VHAP beneficiaries. Another commenter stated that coverage of dental emergencies under the general assistance program is not adequate to cover

dental emergencies of VHAP beneficiaries and believed the department will experience an increase in dental emergencies at hospital emergency rooms that will lead to increasing program costs.

Response: The department expects individuals without dental coverage who have a dental emergency to seek coverage for that emergency through the general assistance program. General assistance will pay for limited treatment to remedy pain, bleeding, or infection for qualified individuals.

Comment: One commenter requested language be added that describes how emergency dental situations involving pain or infection can be covered and whether the primary care provider (PCP) can prescribe medications or authorize procedures to avoid ongoing medical problems that could lead to increased costs.

Response: Beneficiaries may seek emergency dental treatment through the general assistance program. PCPs and other physicians are expected to treat emergencies within the scope of their practice. The department will not provide reimbursement for procedures authorized by a PCP that are provided only by dentists. However, the department will reimburse all medically necessary procedures provided within the scope of a physician's practice and within the procedures covered in the VHAP managed care benefit.

Comment: One commenter noted the lack of written policy or procedures for the VHAP managed care benefit package.

Response: The department is currently in the final adopting process of written procedures for the VHAP managed care benefit package and intends for the procedures to be adopted on September 1, 2001.

Comment: One commenter stated that different copayment requirements make it confusing for beneficiaries who move between programs and that it would be useful for health care providers and beneficiaries if beneficiaries had cards that indicated which program they were on and their copayment requirements.

Response: The department agrees that beneficiaries who move between programs are often confused about their copayment requirements. To address this situation, the department created the Health Access Member Services unit several years ago to help beneficiaries navigate our health care programs. These programs had become more complex as program changes and additions were authorized by the Legislature. The department does not believe that providing beneficiaries with program-specific cards would benefit consumers because:

- consumers that do move between programs may be further confused by receiving new or additional cards;
- administrative costs would increase due to the need to create more cards;

- confusion would be created due to the time lag between a beneficiary's program change and the time when a card could be produced and mailed to the beneficiary; and
- eligibility and cost sharing information can be provided electronically to the pharmacy at the point of sale, more timely than information provided by the card.

Comment: One commenter asked what clarification or changes were made in sections M103.2 P. 2 and M103.3 P. 6.

Response: The sections in question were dotted to show sections were moved to accommodate the additions required by the budget act.

Comments Received Regarding the Definition of "Drugs" Covered by PATH's VScript Program *(VScript 3202.1)*

Comment: Among the comments the department received on this proposed rule were expressions on dissatisfaction with how PATH defines covered "drugs" in VScript and proposals for changes to this definition.

Response: This part of the VScript program's rules is not included in this proposed rule. In light of this, PATH is treating these comments as a request for an amendment to the VScript rules at 3202.1. The statute governing such requests is found at 3 V.S.A. § 806. The department will respond to these commenters regarding their request for an amendment within the time frame specified in the statute.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Manual Maintenance

Remove		**Insert**	
M103.2 P.2	(99-8F)	M103.2 P.2	(01-18)
M103.2 P.3	(99-8F)	M103.2 P.3	(01-18F)
M103.3 P.6	(99-8F)	M103.3 P.6	(01-18)
M103.3 P.7	(99-8F)	M103.3 P.7	(01-18F)
M150	(96-51)	M150	(01-18F)
M150.1	(96-51)	M150.1	(01-18)
3203	(01-16)	3203	(01-18
3303.1 P.2	(00-14)	3303.1 P.2	(01-18F)
4003.1	(99-12)	4003.1	(01-18F)

M103 Benefit Delivery Systems

M103.2 Managed Health Care Plan System (Continued)

1. Services Requiring Plan Referral

The following services as defined in the State Plan and by regulation are included in the monthly payments made to the managed health care plans subject to negotiated contract provisions and must be accessed through the beneficiary's primary care provider (Medicaid regulatory citations are indicated where applicable):

- inpatient services (M510);
- outpatient services in a general hospital or ambulatory surgical center (M520);
- physician services (M600-M618);
- medical and surgical services of a dentist (M619);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (M613);
- home health care (M710);
- hospice services by a Medicare-certified hospice provider (M715);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (M520, M710);
- prenatal and maternity care (M510, M600);
- medical equipment and supplies (M830, M840);
- skilled nursing facility services for up to 30 days length of stay per episode (M900);
- mental health and chemical dependency services (M721);

NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.

- podiatry services (M630);

2. Self-Referral Services

The following services are also included in the monthly payments made to the health plans, but may be accessed by health plan enrollees from the plan's network providers without a referral from their primary care provider:

- unlimited visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months (M670).

M103 Benefit Delivery Systems

M103.2 Managed Health Care Plan System (Continued)

B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (M755);
- dental care for children under age 21 (M620) and limited dental services for adults up to the annual benefit maximum (M621);
- eyeglasses furnished through the department's sole source contractor (M670);
- chiropractic services (M640);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (M740); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (M810-M812).

C. Cost Sharing

Medicaid beneficiaries enrolled in a managed health care plan, unless they are exempted under M150.1, are subject to the following copayment requirements.

1. Beneficiaries age 21 and older must pay a $3.00 copayment for each dental visit.

2. Beneficiaries must pay the following copayments for prescriptions:

    - $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less;

    - $2.00 for each prescription, original or refill, having a usual and customary charge of more than $30.00 but less than $50.00;

    - $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

The copayment requirements for each prescription will be effective on the later of October 1, 2001, or the date of approval by the Centers for Medicare and Medicaid Services (CMMS), formerly the Health Care Financing Administration.

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program (Continued)

C. Services Requiring a PCP's Referral

The following services must be accessed through the beneficiary's PCP and are subject to the department's prior authorization requirements. Services requiring prior authorization are found in the Provider Manual. (Medicaid regulatory citations are indicated where applicable):

- inpatient services (M510);
- outpatient services in a general hospital or ambulatory surgical center (M520);
- physician services (M600-M618);
- specialty medical and surgical services of a dentist (M619);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (M613);
- home health care (M710);
- hospice services by a Medicare-certified hospice provider (M715);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (M520, M710);
- medical equipment and supplies (M830, M840);
- skilled nursing facility services (M900);
- podiatry services (M630);

D. Self-Referral Services

The following services may be accessed by beneficiaries without a referral from their primary care provider (PCP):

- unlimited visits per calendar year to a PCCM gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- mental health and chemical dependency visits up to benefits of $500 per year. Thereafter, providers must request prior authorization from the department for additional services;
- mental health and chemical dependency services provided by a community mental health center;
- Community Rehabilitation and Treatment Services (CRT)
- one routine eye examination every 24 months (M670) and eyeglasses furnished through the department's sole source contractor (M670);
- transportation services (M755);
- emergency services(M106.4);
- dental care for children under age 21 (M620) and limited dental services for adults up to an annual benefit maximum (M621);

M103 Benefit Delivery Systems

M103.3 Primary Care Case Management Program (Continued)

D. Self-Referral Services (Continued)

- chiropractic services (M640);
- maternity/prenatal (M510, M600);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (M740).

E. Cost Sharing

Medicaid beneficiaries enrolled in the PCCM, unless they are exempted under M150.1, are subject to the following copayment requirements.

1. Beneficiaries age 21 and older must pay a $3.00 copayment for each dental visit.

2. Beneficiaries must pay the following copayments for prescriptions:

    - $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less;
    - $2.00 for each prescription, original or refill, having a usual and customary charge of $30.00 or more but less than $50.00;
    - $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

The $3.00 copayment required for each prescription will be effective on the later of October 1, 2001, or the date of approval by the Centers for Medicare and Medicaid Services (CMMS), formerly the Health Care Financing Administration.

F. Enrollment

1. Choice of Primary Care Provider (PCP)

    A benefits counselor will assist beneficiaries in making an informed decision among the choices described in M103, Options 5 and 6.

    The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision and will provide additional information if requested to do so. If two or more PCCM PCPs are available and no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a PCP using a state-approved algorithm.

M150 Payment System

M150.1 Obligation of Recipients

Copayment from some recipients is required for certain services. The recipient copayment will be deducted from the amount computed to be the Medicaid payment for each service subject to copayment. Federal statutes (specifically, Section 1916 (c) of the Social Security Act) stipulate that "no provider participating under the State (Medicaid) plan may deny care of services to an individual eligible for (Medicaid)...on account of such individual's inability to pay (the copayment)." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of (the copayment)."

Copayment is never required for recipients, who are:

- Patients in a participating long term care facility; or
- Under the age of 18; or
- Pregnant or in the 60-day post-pregnancy period.

Copayments are required for certain services as follows:

1. $50 for the first day of an inpatient hospital stay in a general hospital.
2. $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no copayment requirement for outpatient services.
3. Prescriptions as follows:

   $1.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less,

   $2.00 for each prescription, original or refill, having a usual and customary charge of $30.00 or more.

   $3.00 for each prescription, original or refill, having a usual and customary charge of $50.00 or more.

   The $3.00 copayment required for each prescription will be effective on the later of October 1, 2001, or the date of approval by the Centers for Medicare and Medicaid Services (CMMS), formerly the Health Care Financing Administration.

4. $3.00 per date of service per provider for dental services for recipients age 21 and older.

M150.1 Obligation of Recipients (Continued)

No copayments are required on the following services:

1. Services reimbursed by the Department of Mental Health and Mental Retardation and the Department of Health.

2. Emergency hospital services.

3. Services furnished to women related to pregnancy, including routine prenatal care, labor and delivery, routine postpartum care, and any complications of pregnancy, delivery, or the postpartum period. The postpartum period begins in the last day of pregnancy and extends to the last day of month that is 60 days later.

4. Home Health, hospice, and Home and Community Based Services for the Elderly and Disabled.

5. Services provided by other licensed practitioners. These include:

   - Podiatry.
   - Chiropractic.
   - Audiology.
   - Psychological.
   - Optometric and Optician.
   - Nurse practitioner.

6. Services provided by rural health clinics and federally qualified health care facilities.

7. Eyeglasses, lenses, frames, and related miscellaneous parts.

8. Independent laboratory.

9. X-ray interpretations performed by a physician who has no direct contact with the recipient.

10. Transportation including ambulance.

3203 Copayment and Coinsurance Requirements

Benefits under this program shall be subject to a copayment or coinsurance by the beneficiary.

For beneficiaries with incomes of 175 percent of the federal poverty level or less, the copayment will be:

$2.00 for each prescription, original or refill, having a usual and customary charge of $29.99 or less, or

$4.00 for each prescription, original or refill, having a usual and customary charge of $30.00 or more.

The increases in copayments of $2.00 and $4.00 are effective on the later of October 1, 2001, or the date of approval by the Centers for Medicare and Medicaid Services (CMMS), formerly the Health Care Financing Administration. Until CMMS approval and implementation, beneficiaries will be responsible for their current copayment amounts of $1.00 and $2.00.

For beneficiaries whose VScript group income is greater than 175 percent of the federal poverty level and no greater than 225 percent of the federal poverty level the coinsurance will be 50 percent of the prescription cost.

A pharmacy shall dispense a drug to an eligible beneficiary upon payment of the required copayment or coinsurance.

A drug may also be dispensed to an eligible beneficiary, subject to the required copayment or coinsurance, provided such dispensing is pursuant to and in accordance with any contractual arrangement that the department may enter into or approve for the group discount purchase of drugs. Group discount purchase of drugs means contractual arrangements for the procurement and/or distribution of drugs designed to contain costs which include but need not be limited to volume purchasing through manufacturers, wholesalers or retailers, manufacturers' rebates, or mail order delivery. Contracts will be awarded pursuant to guidelines established by the Agency of Administration in Bulletin 3.5 and subsequent issuances. Prior to the beginning of each fiscal year, the Commissioner shall determine the most practical and cost-effective method of purchasing VScript covered drugs. When a person or business located in Vermont and employing citizens of this state has submitted a bid for the group discount purchase of drugs and has not been selected, the Commissioner of the Department shall record the reason for nonselection. The Commissioner's report shall be a public record available to any interested person. All bids or quotations shall be kept on file in the Commissioner's Office and open to public inspection.

The department shall monitor enrollment in the VScript program on a monthly basis, and shall limit enrollment in the program so that expenditures do not exceed the appropriation available for the program in any fiscal year.

3303 Payment Conditions (Continued)

3303.1 Cost-Sharing (Continued)

The copayment required is as follows:

* $1.00 for each prescription or diabetic supply having a usual and customary charge of $29.99 or less.
* $2.00 for each prescription or diabetic supply having a usual and customary charge of $30.00 or more.
* $3.00 for each prescription or diabetic supply having a usual and customary charge of $50.00 or more.

The required $3.00 pharmacy copayment for each prescription or diabetic supply having a usual and customary charge of $50.00 or more, is effective on the later of October 1, 2001, or the date of approval by the Centers for Medicare and Medicaid Services (CMMS), formerly the Health Care Financing Administration. Until approval by CMMS and implementation, beneficiaries will be responsible for their current copayments of $1.00 and $2.00.

The recipient copayment will be deducted from the amount computed to be the VHAP-Pharmacy payment.

3303.2 Lower of Price for Ingredients Plus Dispensing Fee or Charge

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 3303.3) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

3303.3 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).

a. For multiple-source drugs, the price for ingredients will be the lowest of:

   1. an amount established as the upper limit derived from a listing issued by CMMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or
   2. an amount established as the upper limit by the Office of Vermont Health Access, or
   3. the Average Wholesale Price (AWP).

b. For "other" drugs, the price for ingredients will be 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).

4003 Benefit Delivery Systems

4003.1 Benefits (Continued)

- mental health and chemical dependency services;
  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months.

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- Coverage of limited dental services ends on the later of October 1, 2001, or the Centers for Medicare and Medicaid Services' (CMMS), formerly the Health Care Financing Administration, approval date for the elimination of these services from VHAP wrap-around benefits: dental services, excluding dentures, up to an annual calendar-year benefit maximum of $475.

- eyeglasses furnished through PATH’s sole source contractor;

- chiropractic services;

- family planning services (defined as those services that either prevent or delay pregnancy).